



Report from the Field

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Open Season on Country Doctors

- Our Government and Regulators have declared open season on doctors who choose to practice in small towns and rural areas of our country
- The Bag Limit seems to be as many as can be collected
- The goal seems to be assimilation into clinics and practices that can be uniform and fun stuff like best practices instituted easily

The view from ground zero

- Rural practices are administratively efficient and are associated with high patient satisfaction
- They struggle with added burdens on administrative demands to upgrade to EMR, e-prescribing and PQRS and soon the Value Based Modifier
- They struggle because of increased competition with hospitals to add partners and even additional PA's and FNP's

Open Season on Small Town Doctors

- Causes
- **Regulatory**
- *Hippa, OMB, OIG, CMS, and in some cases CBS*
- *EMRs, e-prescribing, PQRS, Penalties and bonuses*

Medicare Quality Reporting Programs

POTENTIAL PAYMENT AT RISK

	2015	2016	2017 & beyond <i>*proposed</i>
Value Modifier	1%	2%	4%
PQRS	1.5%	2%	2%
Meaningful Use	1%	2%	3-5%
TOTAL	3.5%	6%	11%

The Bottom Line

- Small practices are paid less for doing the same work
- Small practices have lower cost structures and are not associated with the rapid rise in medical costs associated with assimilated practices
- Net Result : Less competitive financial structures and better costs

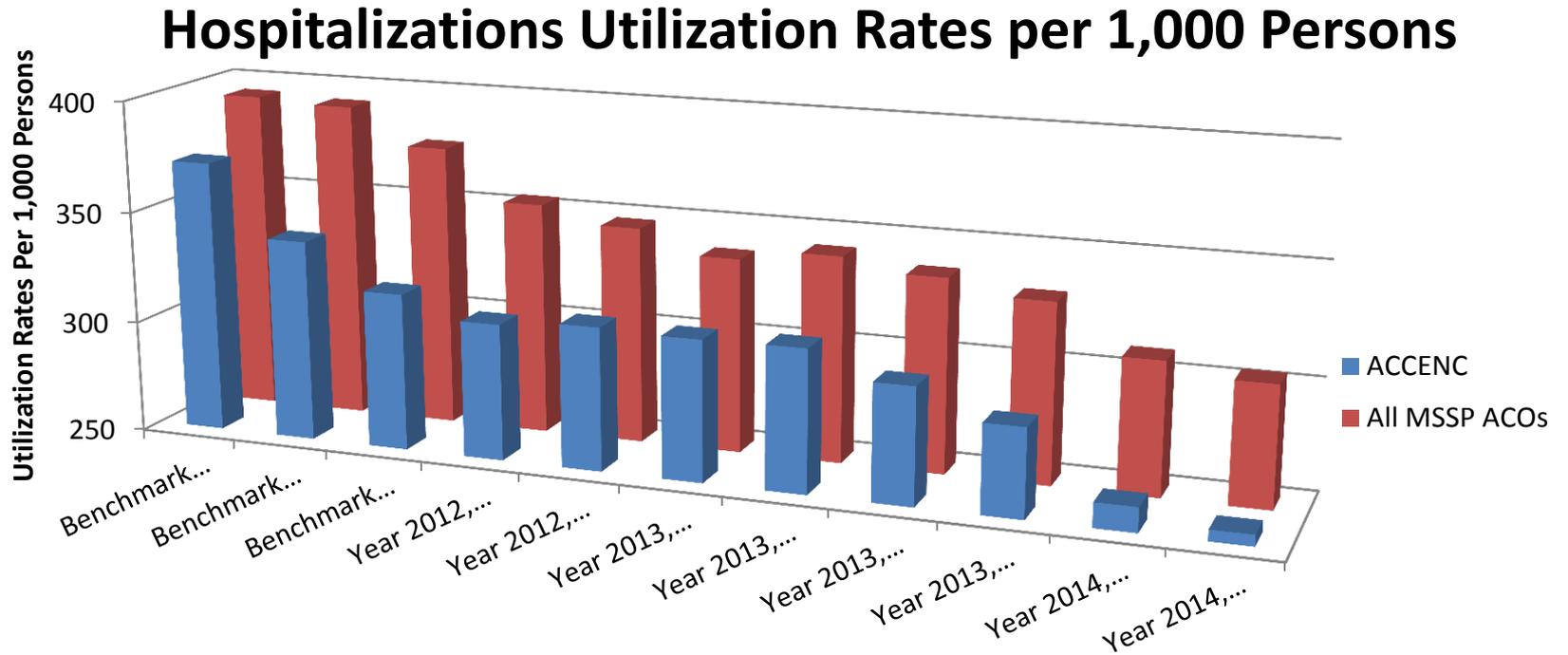
Open Season on Country Doctors

- We need to rethink models and motivations and not define our health care system based on bigger better faster schemes of compensation if medicine in rural areas is to survive

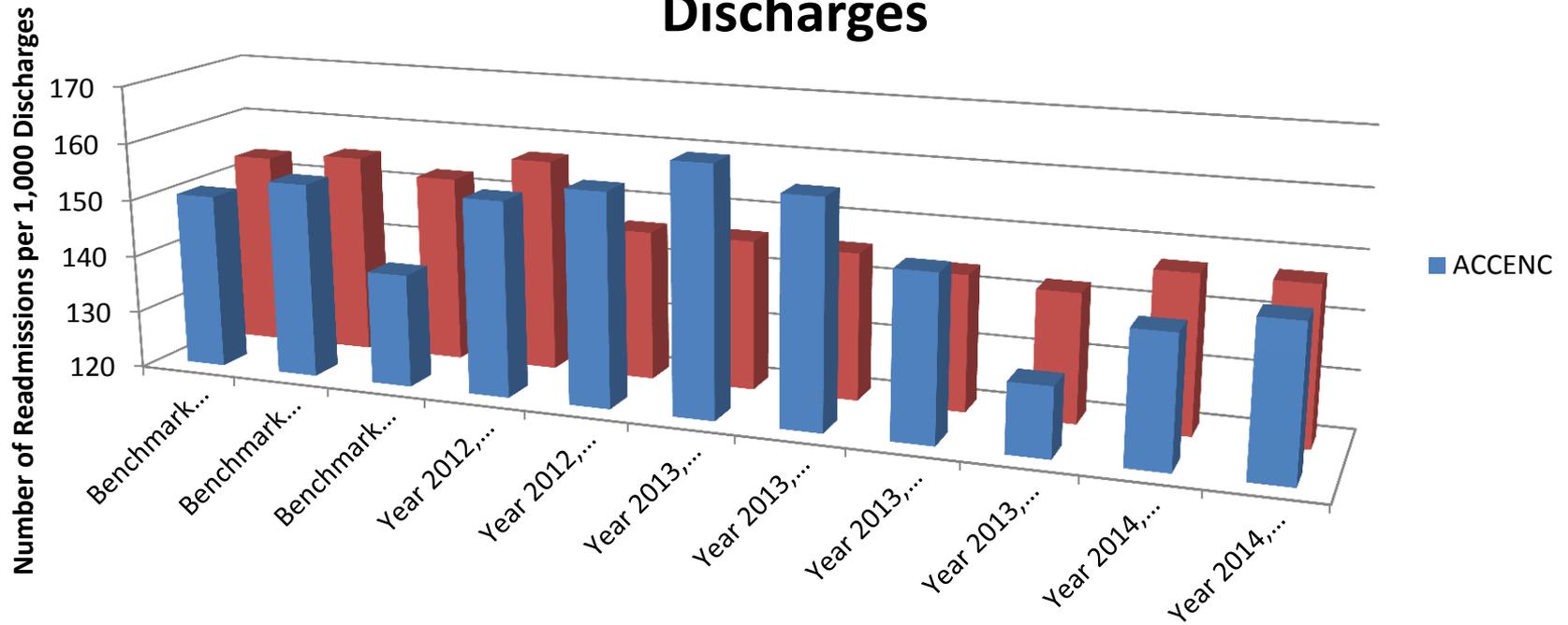
Results of a better cooperative model

- Accountable Care Coalition of Eastern NC
- 15 doctors and 27 total providers
- 2,100 square miles of coverage
- Designed to be the eyes and ears of physicians to fill in current gaps in care coordination and clinical problems that exist
- Around \$68 million a year in medical costs in the patients in the ACO

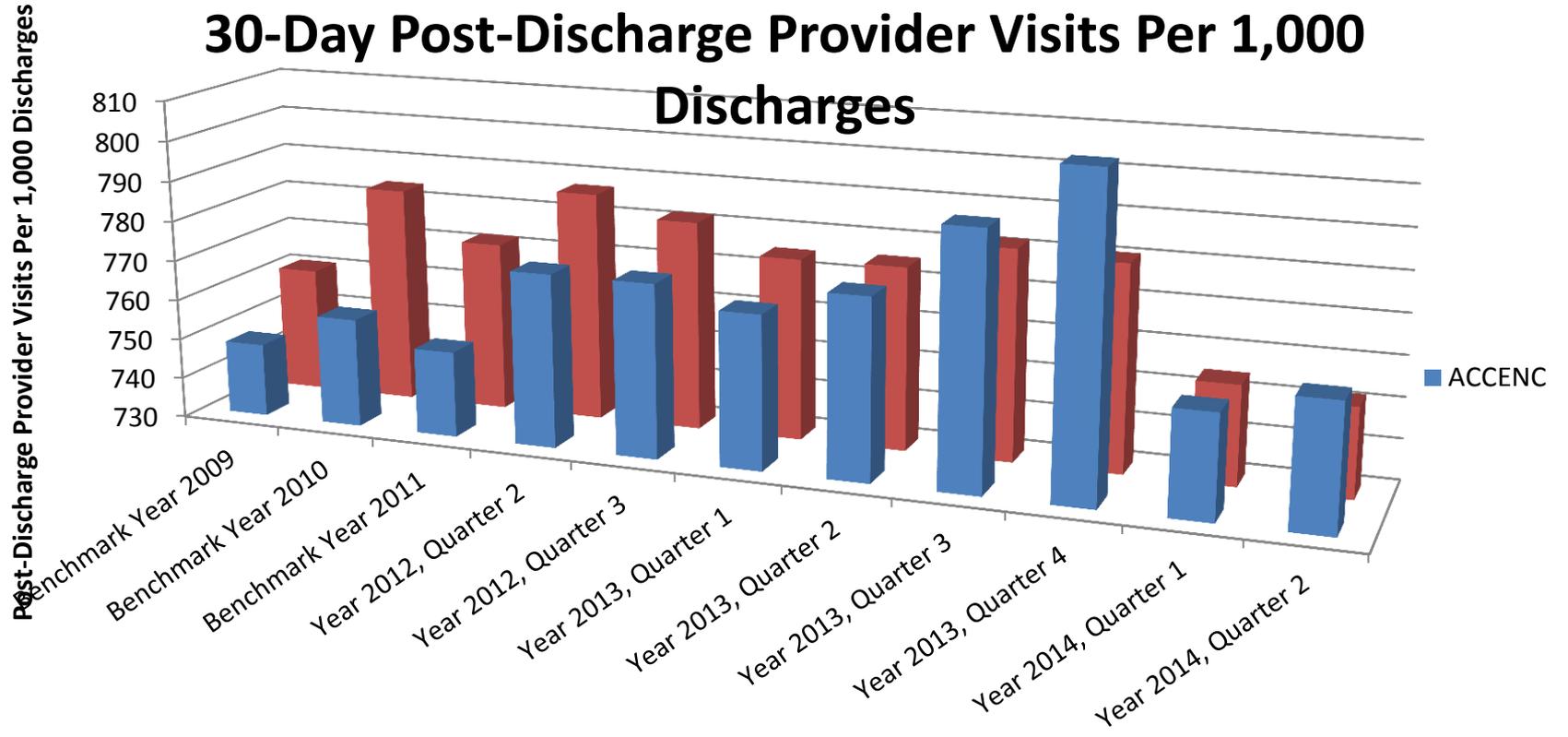
Results



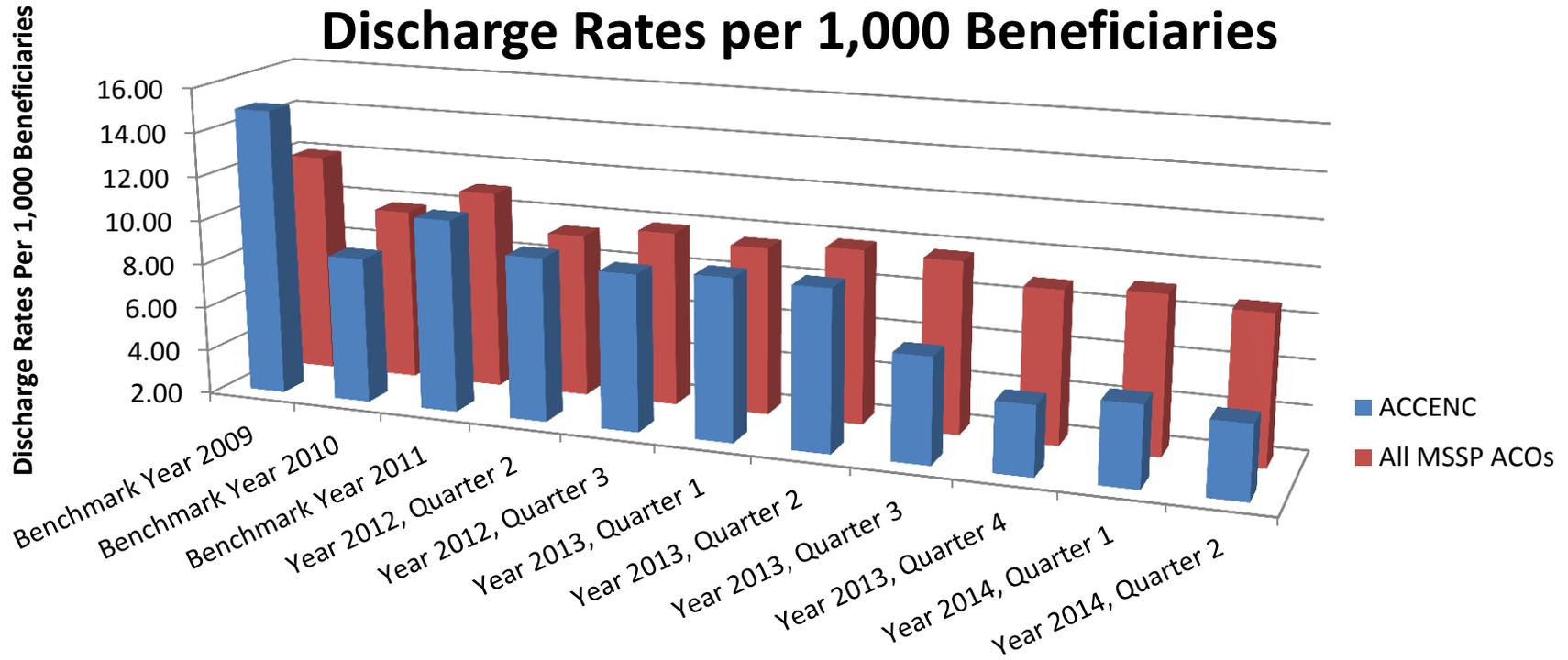
30-Day All-Cause Readmissions Per 1,000 Discharges



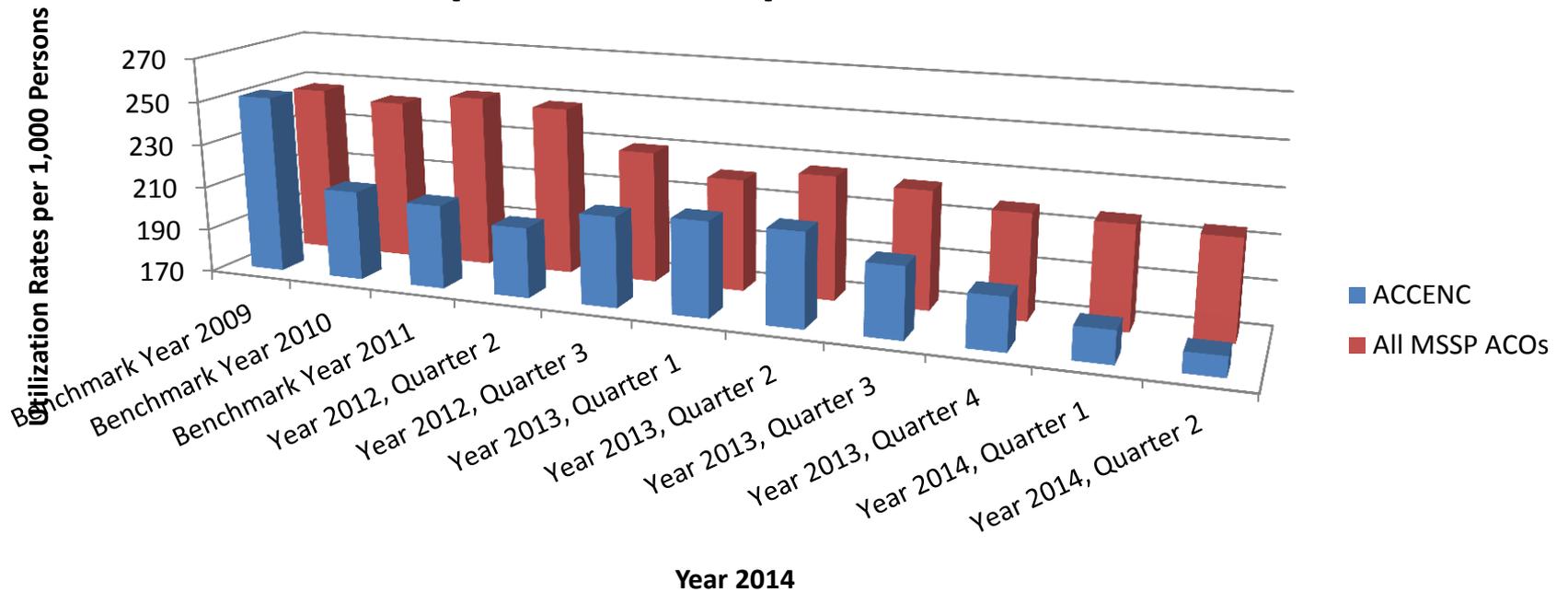
30-Day Post-Discharge Provider Visits Per 1,000 Discharges



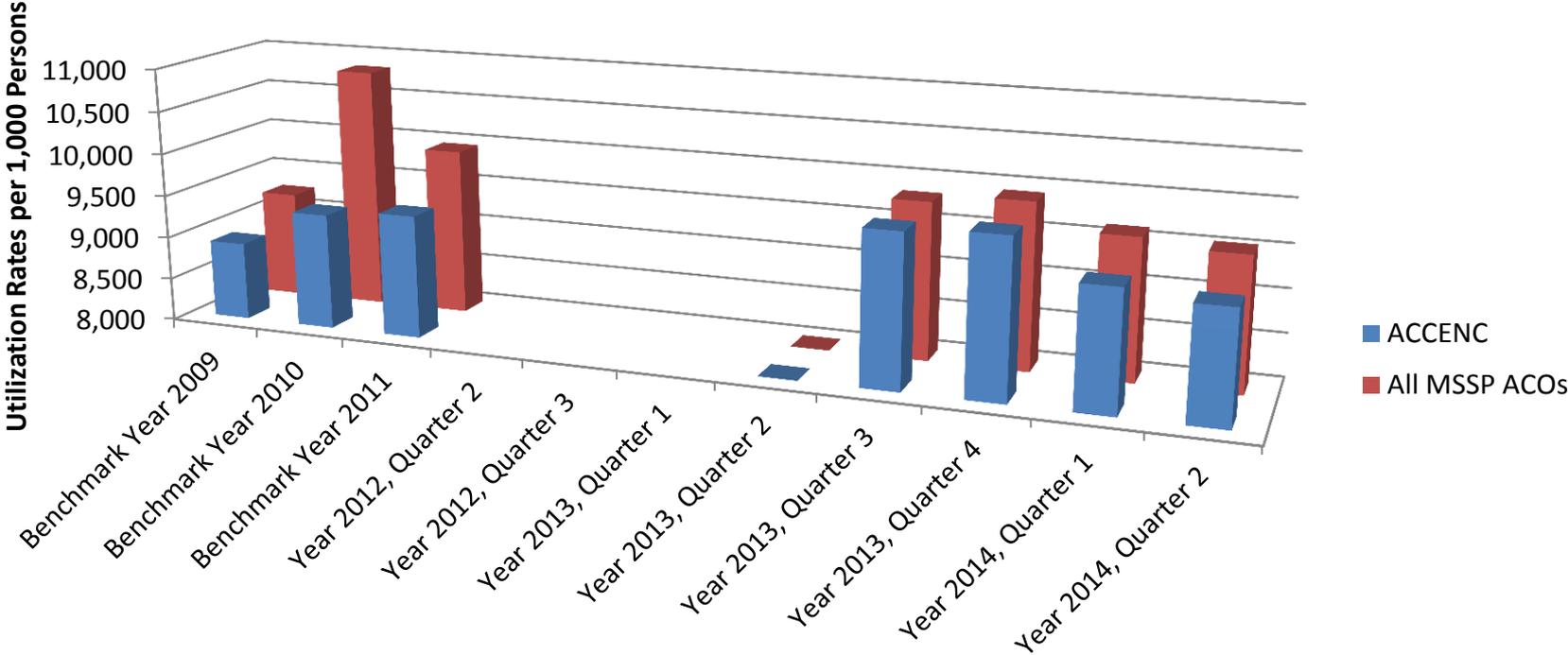
Chronic Obstructive Pulmonary Disease or Asthma Discharge Rates per 1,000 Beneficiaries



Emergency Department Visits That Lead to Hospitalizations per 1,000 Persons



Primary Care Services Per 1,000 Persons



What did we do?

1. Reconnected patients with their primary care doctors after a significant medical event, providing for efficient and effective transitions of care
2. Operated in the background providing critical support and help with care coordination and monitoring of patients
3. Ensured medication compliance and teaching for patients
4. Educated practices and provided infrastructure for better financial reimbursement
5. Emphasized annual wellness visits and preventative care
6. Improved the quality of care and patient satisfaction which was already high with our practices
7. Development of meaningful, actionable data programs

The Take Homes

- Deliver the right care at the right place at the right time
- Rural practices are capable of high quality appropriate care with a better cost basis if supported in the proper structure and manner
- Government needs to develop reimbursement schemes that pay for care not demand the care be provided in a certain location or practice style